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No. 91-2079

In the Supreme Court of the United States

OCTOBER TERM, 1992

GOOD SAMARITAN HOSPITAL, ET AL., PETITIONERS

v.

LOUIS M. SULLIVAN, SECRETARY OF HEALTH AND HUMAN SERVICES

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

BRIEF FOR THE RESPONDENT

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QUESTION PRESENTED

Under the Medicare program, health care providers are reimbursed by the government for expenses incurred in providing medical services to Medicare beneficiaries. Under Part A of the Medicare program, providers are reimbursed for either their "customary charge" or the "reasonable costs" of the services, whichever is less. Congress has granted the Secretary authority to adopt methods for determining costs, and to establish cost limits. 42 U.S.C. 1395x(v)(1)(A). Congress has also directed the Secretary to promulgate regulations that "provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive." 42 U.S.C. 1395x(v)(1)(A)(ii) (clause (ii)). The Secretary has promulgated regulations providing for exceptions to and exemptions from the cost limits in specified circumstances. The question presented is:

Whether a health care provider may obtain additional reimbursement under clause (ii) in excess of the cost limits established by the Secretary even if the provider does not qualify for an exception or exemption under the Secretary's regulations.

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OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1a-17a) is reported at 952 F.2d 1017. The opinion of the district court (Pet. App. 19a-36a) is reported at [Oct. 1989-Sept. 1990 Transfer Binder] Medicare and Medicaid Guide (CCH) ¶ 38,400. The decisions of the Provider Reimbursement Review Board (Pet. App. 37a-54a) are unreported.

JURISDICTION

The judgment of the court of appeals was entered on December 30, 1991. On February 7, 1992, the court of appeals denied a petition for rehearing. Pet. App. 18a. On April 28, 1992, Justice Blackmun granted an

extension of time to file a petition for a writ of certiorari to and including July 6, 1992. The petition for a writ of certiorari was filed June 26, 1992. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATEMENT

1. a. The Medicare program, 42 U.S.C. 1395 *et seq.*, provides for payment of medical expenses for eligible aged and disabled persons. Part A of the Medicare program (Hospital Insurance Benefits) authorizes payment for primary institutional care to providers of services, including hospitals, skilled nursing facilities, and home health agencies. See 42 U.S.C. 1395c to 1395i-3 (1988 & Supp. II 1990).

For the years at issue in this case, Part A providers were reimbursed for the "customary charges" for the services furnished or the "reasonable cost" of the services, whichever was less. 42 U.S.C. 1395f(b)(1).[1] The Medicare statute defines "rea-sonable cost" as "the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services," and directs the Secretary to promulgate regulations establishing the method or methods for determining reasonable cost. 42 U.S.C. 1395x(v)(1)(A). The statute also directs the Secretary to promulgate regulations that "provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive." 42 U.S.C. 1395x(v)(1)(A)(ii) [hereinafter clause (ii)].

[1] Beginning on October 1, 1983, most Part A Medicare claims for hospital inpatient services are reimbursed in accordance with prospectively determined rates under the Prospective Payment System. See 42 U.S.C. 1395ww(d) (1988 & Supp. II 1990); 42 C.F.R. Pt. 412 (1991).

Congress became concerned that, in practice, "reasonable cost" reimbursement allowed providers to recover whatever costs they incurred. H.R. Rep. No. 231, 92d Cong., 1st Sess. 82-85 (1971); S. Rep. No. 1230, 92d Cong., 2d Sess. 188-189 (1972). In 1972, Congress responded to this problem by authorizing the Secretary to promulgate regulations establishing cost limits that would "be recognized as reasonable." Social Security Amendments of 1972, Pub. L. No. 92-603, § 223, 86 Stat. 1393-1394. In 1974, the Secretary promulgated regulations establishing cost limits for certain items and services furnished by providers. See 20 C.F.R. 405.460 (1975), redesignated as 42 C.F.R. 413.30 (1991). The regulations establish a presumption that reimbursable costs may not exceed the applicable cost limits. 42 C.F.R. 413.30(a)(2). The regulations also specify circumstances in which providers may obtain reimbursement in excess of the applicable cost limits. Thus, exemption from the cost limits may be granted to certain providers, such as new providers, sole community hospitals, and small rural hospitals. 42 C.F.R. 413.30(e). In addition, exceptions may be granted in certain situations, such as those involving atypical services, extraordinary circumstances beyond the provider's control, or essential community hospital services. 42 C.F.R. 413.30(f).

b. For the cost years at issue in this case, the Secretary classified providers according to two criteria: (1) an area wage index; and (2) location within or without a Standard Metropolitan Statistical Area (SMSA). The Secretary adopted a wage index in 1979 to "adjust[] for variations in wage levels" among geo-

graphical areas. 44 Fed. Reg. 11,613 (1979). Initially, the Secretary relied on wage data from the Bureau of Labor Statistics (BLS). *Ibid.* But the BLS data were criticized because, among other things, they failed to account for local variations in the proportion of part-time to full-time workers.

In 1984, Congress directed the Secretary to conduct a wage index study to adjust for variations in part-time employees. Medicare and Medicaid Budget Reconciliation Amendments of 1984, Pub. L. No. 98-369, § 2316(a), 98 Stat. 1081. Based on data obtained from that study, the Secretary revised the wage index in 1986 to account for part-time employees. 51 Fed. Reg. 16,772 (1986). Congress provided that the revised index would be applicable only to patient discharges occurring on or after May 1, 1986. Medicare and Medicaid Budget Reconciliation Amendments of 1985, Pub. L. No. 99-272, § 9103(a), 100 Stat. 156.

In 1974, the Secretary decided to use location within an SMSA "as a proxy for an urban location"; locations not within an SMSA "are considered nonurban" or rural. 39 Fed. Reg. 20,168 (1974). Since it is generally "more expensive to operate a hospital in an urban area than in a rural area" (44 Fed. Reg. at 11,613), the cost limit for providers within an SMSA is higher than the cost limit for providers outside of an SMSA. In accordance with the prospective nature of the cost limit regulations, changes to SMSA designations apply only to fiscal years following the effective date of the change. Cf. 49 Fed. Reg. 34,728, 34,736 (1984).

2. a. Petitioners are six rural Nebraska hospitals that exceeded the Secretary's cost limits for some of the years between 1980 to 1984. Petitioners challenged the cost limits and also sought a "suitable

retroactive corrective adjustment[]" under clause (ii) before the Secretary's Provider Reimbursement Review Board. Petitioners contended, *inter alia*, that the cost limits did not properly account for the high proportion of part-time employees in their work force and did not permit rural hospitals to show that they incurred costs similar to those of urban hospitals. The Review Board, which is bound by the Secretary's regulations, determined that it lacked authority over petitioners' legal challenges and granted their requests for expedited judicial review. Pet. App. 37a-54a; 42 U.S.C. 1395*oo*(f)(1).[2]

b. The district court concluded that "the Secretary must * * * allow [petitioners] an opportunity, under clause (ii), to demonstrate that they are entitled to reimbursement of reasonable costs beyond the amount already determined reasonable under the cost limit schedule." Pet. App. 26a. Applying the court of appeals' decision in *St. Paul-Ramsey Medical Center* v. *Bowen*, 816 F.2d 417 (8th Cir. 1987), the district court held that "[t]he Secretary has a statutory duty under clause (ii) to ensure that the necessary corrective adjustments are made whenever the methods of cost calculation fail to reimburse a provider for its reasonable costs." Pet. App. 29a. The court rejected

[2] The Review Board also concluded that it lacked jurisdiction over the claims of petitioners Memorial Hospital (Seward), Memorial Hospital of Dodge County, and St. Mary's Hospital for three cost years because those petitioners had not filed timely individual appeals for those years. Pet. 5 & n.1. In addition, the Health Care Financing Administration (HCFA) rejected a claim by petitioner Memorial Community Hospital that it should be reclassified as an "urban" rather than a "rural" hospital for purposes of the cost limits. Pet. 5. Both the district court (Pet. App. 33a-35a) and the court of appeals (*id.* at 15a-16a) upheld these determinations; petitioners do not challenge them here. Pet. 7 n.2.

the Secretary's argument that clause (ii) "only authorizes a year-end 'book balancing' adjustment" to ensure "that the provider receives what is due under the cost limits as applied." Pet. App. 27a-28a. The district court remanded the case to the Secretary for "consideration of [petitioners'] reasonable expenses in excess of the cost limit rules in effect for the years under appeal." *Id.* at 32a.

3. The court of appeals reversed. Pet. App. 1a-17a.[3] The panel agreed with the Secretary that the Eighth Circuit's prior interpretation of clause (ii) in *St. Paul-Ramsey* was effectively overruled by this Court in *Bowen* v. *Georgetown Univ. Hosp.*, 488 U.S. 204 (1988). Pet. App. 11a. Under *Georgetown*, the panel explained, "clause (ii) does not permit changes in the methods used to reimburse costs, but only corrective adjustments to the aggregate amounts" disbursed to a provider. *Id.* at 12a. Accordingly, clause (ii) "merely allows a year-end book balancing of the monthly installments with the aggregate amount due for the year." Pet. App. 12a. The court rejected petitioners' claims for additional reimbursement under clause (ii), holding that the relief they sought "would amount to a retroactive change in the *methods* used to compute costs that, after *Georgetown*, is invalid." Pet. App. 13a. Such a methodological change would constitute a "second bite at the apple" on claims for reimbursable costs, a result that clause (ii) "does not allow." Pet. App. 13a-14a (citing *Hennepin County* v. *Sullivan*,

[3] As an initial matter, the court of appeals dismissed the appeal of petitioner Mary Lanning Memorial Hospital for lack of jurisdiction under *Torres* v. *Oakland Scavenger Co.*, 487 U.S. 312 (1988). Pet. App. 8a-11a. Petitioners (including Mary Lanning) were appellees as to the question presented in the petition. Consequently, the jurisdictional issue does not arise in this Court.

883 F.2d 85, 92 (D.C. Cir. 1989), cert. denied, 493 U.S. 1043 (1990), and *Sierra Medical Center* v. *Sullivan*, 902 F.2d 388, 393 (5th Cir. 1990)). The court of appeals upheld both the wage index and the SMSA-based cost limit regulations against petitioners' challenges, concluding that "[t]here is nothing arbitrary or capricious about the cost limit methodology used by the Secretary." Pet. App. 14a-15a.

ARGUMENT

Petitioners exceeded the Secretary's cost limits for the years at issue, and they concede (Pet. App. 4a n.4) that they are not entitled to reimbursement in excess of those limits under any exception or exemption established by regulation. Petitioners nevertheless contend that clause (ii) requires the Secretary to make an ad hoc determination whether additional reimbursement in excess of the cost limits is reasonable in this case. The court of appeals correctly rejected that contention. As petitioners note, however, the court of appeals' decision conflicts with the Ninth Circuit's recent decision in *Mt. Diablo Hosp.* v. *Sullivan*, 963 F.2d 1175 (1992). Because the question presented is of considerable practical importance, we do not oppose the granting of certiorari in this case.[4]

1. a. In *Bowen* v. *Georgetown Univ. Hosp.*, *supra*, this Court held that clause (ii) does not authorize the Secretary to adopt retroactive cost limits. The Court applied the rule that "congressional enactments and administrative rules will not be construed to have retroactive effect unless their language requires this

[4] On July 24, 1992, the Ninth Circuit denied the government's petition for rehearing and suggestion of rehearing en banc in *Mt. Diablo*. The Solicitor General has authorized the filing of a petition for a writ of certiorari in that case.

result." 488 U.S. at 208. The Court observed that clause (i) of Section 1395x(v)(1)(A), which authorizes the Secretary to establish cost limit methods, speaks of "providers," while clause (ii), which governs retroactive adjustments, speaks of "*a provider*." 488 U.S. at 210. The Court reasoned:

> The distinction suggests that clause (ii), rather than permitting modifications to the cost-method rules in their general formulation, is intended to authorize case-by-case inquiry into the accuracy of reimbursement determinations for individual providers. * * *
>
> * * * * *
>
> It is also significant that clause (ii) speaks in terms of adjusting the aggregate reimbursement amount computed by one of the methods of determining costs. As the Secretary concedes, the cost-limit rules are one of the methods of determining costs, and the retroactive 1984 rule was therefore an attempt to change one of those methods. Yet nothing in clause (ii) suggests that it permits changes in the *methods* used to compute costs; rather, it expressly contemplates corrective adjustments to the *aggregate amounts* of reimbursement produced pursuant to those methods.

488 U.S. at 210-211. The Court illustrated the distinction between a retroactive change in methods and adjustments to the aggregate amount of reimbursement due under the Secretary's pre-existing methods by citing the Secretary's regulations authorizing adjustments for individual providers "in accordance with an accepted method of cost apportionment." *Id.* at 211-212 & n.2.

In sum, clause (ii), as construed by this Court in *Georgetown*, provides for a year-end adjustment within the framework of the Secretary's cost limit rules and regulations. It does not require the Secretary to make an ad hoc inquiry into the reasonableness of an individual provider's costs without regard to whether the provider has exceeded the applicable cost limits or met the regulatory criteria for an exception or exemption. Such a requirement would greatly undermine the utility of cost limits of general applicability in the vast Medicare program.[5]

b. Petitioners argue (Pet. 11) that they sought only "an individual adjustment to their reimbursement because the cost limits methodology was applied to them in a conclusive fashion, rather than in a presumptive manner," resulting in "inadequate reimbursement of their reasonable costs." Petitioners also contend (*ibid.*) that the court of appeals improperly characterized their claims as "tantamount to a retroactive change in the cost limits rules * * * prohibited by *Georgetown*" and ignored the "dichotomy recognized in *Georgetown* between case-by-case [retroactive] adjudications resulting in adjustments to individual providers[] * * * and across-the-board [prospective] rulemaking by the Secretary." Petitioners' arguments are unconvincing.

[5] The court of appeals' construction of clause (ii) is in accord with the relevant evidence of legislative intent. The 1972 amendments to the Medicare statute were intended to give providers incentives to operate efficiently and reduce Medicare costs. H.R. Rep. No. 231, *supra*, at 82-85. Petitioners' construction of clause (ii) would undermine those incentives by encouraging providers to seek additional reimbursement whenever their costs exceed the Secretary's cost limits.

First, contrary to petitioners' suggestion, the Secretary's cost method rules are presumptive rather than conclusive. As noted above (p. 3, *supra*), providers may rebut the presumption that their costs are unreasonably high by showing that they meet the requirements for an exemption or exception established by regulation. Petitioners concede that they do not qualify for such relief. Nor does the court of appeals' holding deprive petitioners of their right to challenge the Secretary's cost method rules. Indeed, petitioners raised such a challenge in this case, and the court of appeals rejected it on the merits—a holding that petitioners no longer dispute. Pet. App. 14a-15a; see also *id.* at 61a-67a. Having failed in their direct legal challenge, petitioners seek to use clause (ii) to change the Secretary's "methodology * * * to correct what they believe are inequalities in the system." Pet. App. 13a. The court of appeals correctly held that clause (ii) does not furnish a means by which petitioners may obtain "a second bite at the apple." Pet. App. 14a.

2. Petitioners correctly observe (Pet. 7-10) that the courts of appeals are in conflict as to the meaning of clause (ii). The District of Columbia Circuit agrees with the Eighth Circuit that clause (ii) does not "compel the Government, after the fact, to consider whether, as a matter of 'fairness,' claimants should be awarded something more than lawful regulations required. * * * [T]he clause does not authorize a post hoc reassessment of the efficacy of the relevant standard, only of the calculations made pursuant to that standard." *Hennepin County* v. *Sullivan*, 883 F.2d 85, 93 (D.C. Cir. 1989), cert. denied, 493 U.S. 1043 (1990). Cf. *Sierra Medical Center* v. *Sullivan*, 902 F.2d 388, 393 (5th Cir. 1990) (clause (ii) "does not permit HHS to change the *methods* used," but rather

"permits HHS to adjust the *aggregate amounts* of reimbursement that applying those methods produced"). In contrast, the Ninth Circuit in *Mt. Diablo Hosp.* v. *Sullivan*, 963 F.2d 1175 (1992), has rejected that approach and held that "hospitals are entitled to make a showing that their compensation was inadequate and that they are entitled to a retroactive adjustment awarding them * * * 'reasonable' costs in excess of the limits prescribed by the Secretary."[6] *Id.* at 1183. See note 4, *supra*.

As noted above, see note 1, *supra*, Congress has adopted a new Prospective Payment System that governs provider reimbursement for most hospital inpatient services provided since October 1983. Although this change reduces the long-term significance of the question presented in this case, the

[6] Prior to this Court's decision in *Georgetown*, the courts of appeals did not agree on the interpretation of clause (ii). *See, e.g.*, *Medical Center Hosp.* v. *Bowen*, 839 F.2d 1504 (11th Cir. 1988); *Regents of the Univ. of Cal.* v. *Heckler*, 771 F.2d 1182 (9th Cir. 1985); *Daughters of Miriam Center for the Aged* v. *Mathews*, 590 F.2d 1250 (3d Cir. 1978); *Springdale Convalescent Center* v. *Mathews*, 545 F.2d 943 (5th Cir. 1977); *Whitecliff, Inc.* v. *United States*, 536 F.2d 347 (Ct. Cl. 1976), cert. denied, 430 U.S. 969 (1977); *Kingsbrook Jewish Medical Center* v. *Richardson*, 486 F.2d 663 (2d Cir. 1973). This pre-*Georgetown* conflict, standing alone, would not warrant certiorari. The decision in this case demonstrates that the courts of appeals are capable of changing their views on this issue in light of *Georgetown*. There now is, however, a post-*Georgetown* circuit conflict on the meaning of clause (ii).

Petitioners also assert that the Secretary has acted inconsistently under clause (ii), citing it "as authority for numerous other actions apart from year-end book-balancing or retroactive rulemaking." Pet. 8 n.3 (collecting authorities). To the extent that the Secretary advocated other positions concerning clause (ii) prior to *Georgetown*, he has now conformed his view of clause (ii) to the Court's decision in that case.

question nonetheless continues to have considerable practical importance. The Secretary's cost limits continue to apply to skilled nursing facilities and home health agencies. HCFA informs us that 6,211 skilled nursing facilities and 6,009 home health agencies participate in the Medicare program. Those providers receive $7.65 billion annually in Medicare payments, and HCFA estimates that approximately $400 million in claims are disallowed each year as a result of the cost limits. In addition, 2,832 hospitals are excluded from the Prospective Payment System and instead are subject to rate-of-increase limits under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), 42 U.S.C. 1395ww(b) (1988 & Supp. II 1990), that are similar to the Secretary's cost limits. See 42 C.F.R. 412.22-412.23 (1991). The question presented in this case may affect those hospitals as well. The sheer number of providers affected, as well as the significant amounts of money at stake, reflect the continuing importance of the issue.

In view of the conflict in the courts of appeals, and the importance of the question presented, we do not oppose the petition for a writ of certiorari in this case.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted.

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